Tennessee Department of Human Services

Child Care Provider Medical Report

A. TO BE COMPLETED BY PROVIDER:

Name:_____ Birth Date: _____

Address: _____

Street City State Zip Code

I, , hereby authorize the physician(s) name below to release information (Provider/Patient's Signature) to the Department of Human Services for approval/licensure or employment as a child care provider.

Name of Physician(s):	Address:

Purpose of Examination:

☐ Initial Employment

☐ Re-examination

Type of Activity In Child Care (check all that apply):

☐ Caregiver ☐ Food Preparation ☐ Driver ☐ Facility Maintenance

☐ Other: _____

B. TO BE COMPLETED BY PHYSICIAN(S):

1. How long have you known this patient or have had knowledge of their medical history? _____

2. In your opinion, does this person have:	YES	NO
a. The agility to move quickly to keep pace with toddlers?	☐	☐
b. The stamina to remain alert and energetic for 8 hours or more?	☐	☐
c. Any condition which requires restriction of activity or which could affect patient's temperament and interaction with children? (If so, explain in Number 3)	☐	☐

3. Specify any physical, mental, or emotional limitation affecting this person's ability to care for a group of children.

_____

_____

_____

4. Is this patient currently taking any medications which could affect their work role or interaction with children?

☐ Yes ☐ No If yes, please explain: _____

_____

5. Additional Comments:

_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Physician's Signature Date

TDHS staff should check the "Forms" section of the intranet to ensure the use of current versions. Forms may not be altered without prior approval.

Distribution: *RDA: Pending*